

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS

Our Camp infirmary is well stocked with medications most commonly used/needed (as listed on stock medication sheet, other side). If you choose to send a prescription or non-prescription (over the counter) drug to camp with your child, for EACH medication you need to complete this form and have it signed by the prescribing physician.

NO DRUG WILL BE DISPENSED WITHOUT THIS COMPLETED FORM

Please copy this form for each drug you want dispensed

Authorized prescriber or dentist's order: Date ____/____/____
Name of Child _____ Date of birth ____/____/____
Street Address _____ City/Town _____ State _____
Condition for which drug is being administrated during camp _____

DRUG: Name of drug, dose and method of administration _____

Times of Administration: __, __, __ Medications shall be administered from ____/____/____ - ____/____/____
Relevant side effects to be observed, if any _____

If there are any side effects, plan for management _____

Is this is a controlled drug? _____

Allergies, reaction to, or negative interaction with food or drugs? If YES, list _____

The authorized prescriber's or dentist's name _____ Phone () _____
Type or Print

Signature of prescribing physician _____
Address: _____

Authorization by Parent/Guardian for the administration of the above medication:

Date: ____/____/____

I hereby request that the above medication, ordered by the authorized perscriber/dentist for my child _____ be administered by the nurse or by camp personnel with current Medication Administration Training.

I understand that I must supply HARTFORD COUNTY 4-H CAMP with the prescribed medication in the original container dispended and properly labeled by an authorized prescriber, dentist or pharmacist. Over the counter medication shall be in the original container labeled by the parent with the child's name. Drugs must not have passed the expiration date.

I understand that this medication will be destroyed if it is not picked up within one (1) week following the end of my child's camp stay.

Name of Parent/Guardian _____
Signature of Parent/Guardian _____
Relationship to Child _____ Street Address _____
City/Town _____ State _____ Zip Code _____ Phone _____

FOR CONTROLLED DRUGS ONLY -TO BE COMPLETED AT CHECK IN

Date _____ Number of tablets received: _____ Parent's initials _____ RN initials _____

This section is to be completed by parent/guardian

This infirmary at Hartford County 4-H Camp stocks the following over-the-counter medication and prescription medications. They are administered by a registered nurse or certified medication administrator in accordance with the standing orders of our camp physician. It is not necessary to bring any of these medications to camp unless your child receives them routinely. **Draw a line through and initial any medications you DO NOT want your child to receive.**

- Aurodri ear drops _____
- Bacitracin _____
- Benadryl Tablets _____
- Benadryl elixir _____
- Benadryl cream/spray _____
- Bengay _____
- Calamine _____
- Caladryl _____
- Cloraseptic throat spray _____
- Dimetapp _____
- Epipen injection for SEVERE, LIFE-THREATING allergic reaction _____
- Hydrocortisone cream _____
- Ibuprofen (Advil or Motrin) _____
- Imodium AD _____
- Lostrin AF _____
- Maalox _____
- Milk of Magnesia _____
- Mylanta _____
- Neural borate rinse _____
- Paste of Adolf's meat tenderizer-unseasoned _____
- Erythromycin antibiotic eye ointment _____
- Rhuligel _____
- Robitussin _____
- Robitussin DM _____
- Sudafed _____
- Tinactin cream _____
- Tobrex eye drops _____
- Tylenol _____

Medication Authorization

I hereby give permission to Hartford County 4-H CAMP health care personnel to administer any of the above medication (or their generic equivalents) that I have not drawn a line through and initialed per the Standing Orders of the Camp Physician.



Signature of Parents/Guardian _____ Date _____
(or participant if 19 or over)